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Commissioner Robert E. Nicolay, CPA
Chair, Certificate of Need Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

RE: Recommendations to Improve the Certificate of Need and Health Planning Program in Maryland

Dear Commissioner Nicolay

Thank you for soliciting comments on how to improve the CON process. As a health care planner for the last thirty years, I have a long abiding respect for Maryland's health planning efforts and have a desire that it be effective and well respected. I worked for the Commission's predecessor agencies for approximately ten years, first as a planning and CON analyst, then as the Chief of Plan Development, and, finally, as the Director of the CON program. I also taught a course in comprehensive health planning at the Johns Hopkins School of Public Health for nine years.

For the last twenty years, I have operated my own health planning consulting practice, assisting clients in strategic planning, market studies, development of outreach programs, CON assistance, and other matters. My clients have included hospitals, long term care providers, physician groups, developers, and others. My experience with Maryland's CON program has been continuous over the last twenty years. While I have participated in the Maryland Hospital Association ("MHA") Task Force on which the MHA comments are based, these comments are my own and not made on behalf of any client.

I offer the following recommendations about how Maryland could improve its CON process. I have saved perhaps the most important one (Revise the State Health Plan) for last simply because it requires the longest discussion. However, without a clear vision and policy promulgated through a revised State Health Plan, it will be difficult for the industry to be responsive to the Commission.

1. Simplify the Format of Decisions

The Commission could expedite time and save paper by simply having a check list for those standards with which a project is consistent. There is no need for a full

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discussion of how the applicant met the standards. Discussions could be reserved for those standards with which the project is not consistent.

2. Revert To Using Completeness Review For What It Was Intended

Currently, the Commission has stopped making a distinction between "completeness" and "additional information" questions. The Commission should go back to making such a distinction. Completeness questions should only address whether a component of the application was not completed. It should not be a judgment on how well it was completed. That should be reserved for additional information questions. I have no objection to the Commission asking additional information questions, but applicants should not have to wait for docketing until after they are answered. This is especially true for questions in which the Commission appears to be asking applicants to identify potential sources of review standards, such as square footage or inflation benchmarks. Applications could be docketed considerably sooner than they currently are.

3. Modify the Commission's Perspective on Bed Need

a. The projection of need on a jurisdictional basis may make sense in single hospital jurisdictions, but it does not make sense in Baltimore City, where hospitals have very broad service areas that include several jurisdictions. The Commission should consider a methodology that acknowledges that hospitals in Baltimore City serve many jurisdictions and should adopt a mechanism that allows for bed expansion in Baltimore City hospitals that can demonstrate need. The current State Health Plan ("SHP") allows hospitals to apply the Commission's acute care bed need methodology to their service area, but the methodology is so complex that it is not easily accomplished (and, indeed, may not be possible). Many hospitals in Baltimore City have aging and outdated physical plants that do not meet contemporary architectural standards and need modernization or replacement. Such expensive investments should not be made without allowing strong hospitals that can demonstrate historical growth to increase their capacity, even though the jurisdiction shows no additional need.

b. The "140 percent rule" (under which the number of beds for every hospital is licensed based on 140 percent of the prior year average daily census) is a Maryland law, and yet, capacity is not approved to allow hospitals to comply with it. The 140 percent rule translates to a hospital operating at 71.4 percent occupancy (1/1.4 = .714). Currently, the State Health Plan ("SHP") requires hospitals to plan at a Medical/Surgical/ Gynecological/Addictions ("MSGA") occupancy level of between 70 and 83 percent, depending on the number of MSGA beds there are in the jurisdiction. The Commission requires applicants to complete the statistical projections in Table 1 of the CON application based on an MSGA occupancy of approximately 80 percent for most jurisdictions. As MSGA beds comprise the majority of beds in a hospital, the facility's overall occupancy is approximately 80 percent. This does not comport with the law, because the hospitals' licensed beds will be calculated at 71.4 percent occupancy based on the 140 percent rule. Hence a hospital may be licensed for 200 beds but only has the capacity to hold 180. As long as the 140% rule is the law, the Commission should be required to allow hospitals to

comply, rather than force them to perpetuate a myth. The industry is caught between two inconsistent policies. One is based on the legislature's intent that hospitals operate at 71.4 percent based on licensed beds and the other is a regulation that is inconsistent with the law. The Commission should state in the SHP that the facility's occupancy should be 71.4 percent to be consistent with the law.

c. The Commission's recent focus on physical capacity versus licensed capacity is based on the misconception that old patient rooms that cannot meet contemporary architectural standards should continue to be used. The counting of "headwalls" and the fear that previously semiprivate rooms (that have been converted to private rooms) will be re-converted back to semiprivate rooms is a concern that misses the mark. To my knowledge, no hospital wants to re-convert a room that is too small by contemporary standards back into a semi-private room, except in extreme circumstances, such as a terrorist attack. Nor are old rooms that have been converted to other uses (such as offices) desirable as modern patient rooms. It is just not useful in the day-to-day operation of the hospital. While it is easy to cap off older head walls and gas lines to comply with the Commission's current concerns about the space being reconverted to inpatient use, it is costly and unnecessary. The Commission should stop requiring hospitals to perform expensive and time consuming surveys of old rooms and old square footage that are simply not going to be put back into use. If the use of older physical capacity is a genuine issue with some hospitals, it is not a concern that merits the emphasis that the Commission has recently given to it. It is akin to swatting a fly with a sledgehammer.

d. Currently, hospitals are basing their projects on projections to 2015. While it is true that the further out one projects, the greater the chance of error, the cost of major construction projects (usually in the hundreds of millions of dollars) demands that hospitals not simply invest for the short term. The Commission should realize this and consider extending the target year of the projections and/or allow hospitals to construct shell space or to maintain vacated space as shell space (discussed separately below under the MHA identified shell space issue).

4. Promulgate All CON Review Standards

The Commission should specifically cite in regulation any outside sources that it wants to use in evaluating CON applications, as it does with the Marshall and Swift Valuation Service. For example, the Commission has recently been asking applicants who are modifying their Emergency Departments to address the American College of Emergency Physicians *Guide to Emergency Room Design*. The Commission should specify these types of sources in regulation and not be allowed to establish new standards on an use ad hoc basis.

5. Allow Hospitals to Have "Shell Space" when It Makes Sense

Often, particularly in these days of low interest rates and high construction inflation, constructing shell space makes a great deal of sense. This is true both with regard to new construction and the vacating of existing space because services are being moved into

newly constructed space. The Commission should identify the conditions under which shell space is acceptable and allow applicants to include shell space in their projects under those conditions.

6. "Fast Track" Certain Kinds of CON Reviews

Not every project should be reviewed with the same level of intensity and staff time. Some projects simply do not demand the amount of staff time and effort currently being expended. Certain projects should be subject to a lesser review with a shorter review period. If one were to study past projects, one would find that such projects are ultimately approved with little or no changes. These projects could be "fast tracked."

The following types of projects should be fast tracked.

1. Renovation projects-no new beds or services
2. New construction no additional beds or services (note "additional" – this means that building private rooms and converting existing semi-private rooms to private would be okay.)
3. Renovation or new construction projects-new beds that are at or below the minimum of the Commission's bed need projections
4. Medical Information Systems. (Though I don't think that these should be subject to CON review at all – see comments below.)
5. Increases to capacity that meet current and historical needs that are within the capacity limitations of the SHP.

7. Consider Information Technology (IT) to be Exempted Medical Equipment or Business Equipment.

Unless the Commission can identify a legitimate reason to review these projects, they should be considered comparable to medical equipment (CT, Cath, etc.) and business equipment, which are exempt from CON review. I believe that this could be accomplished through regulation.

8. Change the CON Application Modification Regulations

In the past, a Reviewer could request that an applicant make changes to a proposed project at any time during the review. This flexibility was deleted from the regulations approximately 5 years ago. The CON regulations should state that changes to a project under review resulting from requests made by Commission Staff or a Commission Reviewer may be made at any time and will not result in re-docketing of the application.

In addition, COMAR 10.21.01.08.E(2) states:

(2) Once submitted to the Commission, an application may be modified until the 45th day after docketing. After the 45th day, an application in a comparative review may be modified only with the consent of all applicants in the comparative review.

The ability to change a project after the 45th day should not be limited to comparative reviews if all of the parties to the review agree. :

9. Change the Scheduled Review Procedures

While Scheduled Reviews appear to be a good idea, in fact, recent experience has shown that they actually delay the process. For the first time in memory, the Commission had to send applicants letters explaining that it would not meet the allotted time it has to perform completeness reviews because of the number of applications it received on the filing date. The Commission should reserve the ability to hold Scheduled Reviews but allow applicants to file applications as they need to. This would spread the workload out over the year instead of concentrating all of the work at the same time.

10. Consider Eliminating CON Coverage of Home Care and Hospice

I have long been an advocate of eliminating CON for Home Care and Hospice services. In 1982 when I was the Director of the CON program, I testified before the legislature in favor of their deregulation. I supported the Commission's own attempt at deregulation in the 1990s. I do not believe that health care planners can project the need for a specific number of home care or hospice agencies when there is no limiting "bricks and mortar" that help define capacity. The capacity of any home care or hospice agency is only limited by available nursing staff or volunteers it can recruit.

In addition, home care also only represents one of at least three providers in its filed. The Commission does not regulate Residential Service Agencies or Nurse Registries. Therefore, it cannot truly limit capacity.

Over the years, the CON regulation has served only to impose a moratorium on new home care and hospice agencies. Continued regulation of home care has survived because the industry is split on the issue and, therefore, has opted for the comfortable inertia of protected franchises. It also has had the political power to stop legislation proposing deregulation.

The Commission should consider why it regulates home care and hospice and continue to regulate it only if it can demonstrate that it can genuinely hold down cost or have some other demonstrable benefit. It should not regulate it if it will do what the Office of Health Care Quality already does in licensure. If the Commission continues to regulate home care and hospice, it should recognize that it is doing so for political reasons, and not include a methodology projecting need in the State Health Plan.

11. Eliminate CON for the Closure of a Facility or Service.

Requiring a CON for closure of a facility or service should not require a CON. The Commission cannot require a provider who wants to close to stay open. Providers who

want to close a facility or service should simply be required to notify the Commission.

12. Revise the State Health Plan

I consider revising the SHP the most important recommendation. Most of the SHP sections are so old that they should all be revisited. The Commission has not undertaken a comprehensive, integrated revision of the SHP in many years. Consequently, the Commission does not appear to have a comprehensive vision of where the health system should be headed, and many standards in the sections are no longer relevant to improving health care. The SHP needs a complete overhaul and express what the Commission wants to achieve through the CON process. The CON process is only an implementation tool for exercising the Commission's vision that it articulates and promulgates in the SHP on how to respond to problems that it sees in the system. The SHP can have great authority. The SHP should drive the CON process.

The Commission is also responsible to tell the regulated industry what it wants by promulgating its proposed policies and standards as regulations. This is required under the Administrative Procedures Act, and results in better relations with the regulated industry. The kind of "give and take" that occurs through the plan development process, and the clarity of policy that results, leads to mutual respect between the industry and the regulators. Currently, the lack of planning efforts has marginalized the Commission. The industry does not know what the Commission thinks (except by reading the last CON decision, which might change in the next decision). They often do not know the Commission Staff. It would benefit the Commission to have more visibility through an active planning process.

As I said previously, many of the standards are obsolete, and the Commission should take a fresh approach to developing new standards. Every standard should address a documented problem in health care delivery. The Commission should also demonstrate a standard will be effective in resolving the identified problem and improve the system.[1]

As an example of how the current standards are obsolete, I will review the standards in the Acute Inpatient Services section of the SHP. The following standards should be eliminated or substantively modified:

Section .06A(2). <u>Utilization Review and Control Programs</u>. Each hospital shall participate in or have utilization review and control programs and treatment protocols, including written policies governing admission, length of stay, and discharge planning and referral, which conform to the requirements of Health-General Article, §19-319(d), and enforcing regulations.

This need not be a standard. Every hospital must have a UR program.

1 I also believe (and argued for this when I was the Chief of Plan Development) that each standard should be accompanied by an economic impact statement that estimates the cost of the policy to the industry and the health care system. The Commission should employ a health economist who would assist it in doing such analysis. However, I did not win on this issue when I was the responsible for setting such policies.

Section .06A(3). Travel Time. Medical/surgical/gynecological/addictions, critical and progressive care, obstetrical, and pediatric services shall be available within 30 minutes' one-way average automobile travel time under normal driving conditions for at least 90 percent of each health service area's population.

This standard is met in every jurisdiction. It need not be in the SHP.

Section .06A(4). Information Regarding Charges. Each hospital shall provide to the public, upon inquiry, information concerning charges for and the range and types of services provided.

All of my clients have included in their Patient Handbook a statement that the patient has a right to understand their charges. This need not be a standard. Everyone meets it.

Section .06A(5). Charity Care Policy.

(a) Each hospital shall develop a written policy for the provision of complete and partial charity care for indigent and Medicaid patients to promote access to all services regardless of an individual's ability to pay.

(b) Public notice and information regarding a hospital's charity care policy shall include, at a minimum, the following:

(i) Annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) Posted notices in the admission, business office, and, if existing, emergency room areas within the hospital; and

(iii) Individual notice provided to each person who seeks services in the hospital at the time of preadmission or admission.

(c) Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

I think that the Commission has a role to play in improving charity care if there is a problem. However, this standard should be eliminated because all hospitals have policies on charity care, and every hospital with which I have worked has advertised the availability of charity care and has posted notices. I recognize that not all hospitals have charity care policies that state that "decisions on probably eligibility will be made within two business days of the initial application." However, it is in a hospital's interest to make such findings as soon as possible, so that the payment status is resolved sooner than later. The

Commission should be required to demonstrate that there is a problem with patients obtaining charity care in Maryland and that the requirements of this standard are effective in resolving that problem. Otherwise, the charity care standard should be eliminated.

Section .06A (6) Compliance with Quality Standards. Each hospital shall be able to demonstrate upon request by the Commission, compliance with all-mandated federal, state, and local health and safety regulations, applicable Joint Commission on Accreditation of Healthcare Organizations and other appropriate national accrediting organization standards, applicable state certification standards, unless otherwise exempted by an appropriate waiver.

This standard should be eliminated, as every hospital must meet licensure and other standards and be accredited by JCAHO.

Section .06A(7). Transfer and Referral Agreements.

(a) Each hospital shall have written transfer and referral agreements with:

(i) Facilities capable of managing cases which exceed its own capabilities.

(ii) Facilities which provide inpatient, outpatient, long term, home health, aftercare, follow-up, and other alternative treatment programs appropriate to the types of services the hospital offers.

(b) Written transfer agreements shall meet the requirements of Department of health and Mental Hygiene regulations implementing Health-General Article, §619-308.2, Annotated Code of Maryland and shall include, at a minimum, the following:

(i) A mechanism for notifying the receiving facility of the patient's health status and services needed by the patient prior to transfer;

(ii) That the transferring hospital will provide appropriate life-support measures, including personnel and equipment, to stabilize the patient before transfer and to sustain the patient during transfer.
(iii) That the transferring hospital will provide all-necessary patient records to the receiving facility to ensure continuity of care for the patient; and

(iv) A mechanism for the receiving facility to confirm that the patient meets its admission criteria relating to appropriate bed, physician, and other services necessary to treat the patient.

This standard should be eliminated or (at least, modified) because every hospital has transfer agreements and most of them are years, if not decades old. Again, the

Commission should be required to demonstrate that there is a problem in patient transfers that this standard effectively addresses. If there is a problem, it would be better to require that all hospitals have transfer policies that govern all transfers, since a hospital could easily transfer patients to a facility with which it does not have a transfer agreement, even though it can show the Commission that it has agreements with other facilities. The Commission should identify the perceived problem before it establishes a standard.

Section .06A (8). Outpatient Services. Each hospital shall offer outpatient diagnostic and treatment services to support its inpatient services, either directly or through referral.

This standard should be eliminated because every hospital meets it one way or the other. Document the provision of outpatient services either directly or through referral is simply a waste of effort for both the hospital industry and the Commission.

Section .06A (9) Interpreters. Each hospital shall have staff or volunteer interpreters available or on call to translate for deaf and non-English speaking patients and families who do not otherwise have interpreters available to them.

While I was responsible for establishing this standard in 1979, it is irrelevant today. All hospitals now have interpreter services. If the Commission can document that cultural groups in Maryland do not have reasonable access to important health materials that they can understand and wants to have a standard on this issue, it should require hospitals to identify the major cultural groups it serves and show that they have patient education materials in those languages. This would require a lot of hospitals to purchase or develop them, but that would be a social good.

Section .06A (10) In-Service Education. Each hospital shall institute or maintain, or both, and be able to document standardized in-service orientation and continuing education programs for all categories of direct service personnel, whether paid or volunteer.

This standard should be eliminated because every hospital provides inservice education to their employees and volunteers.

Section .06A(11) Overnight Accommodations. Each hospital shall make available information concerning nearby overnight accommodations to the family of each patient during that patient's stay in the facility.

This standard should be eliminated because every hospital provides information on overnight accommodations.

Section .06A (12). Required Social Services. Each hospital shall have social services available to patients and families, and written guidelines and procedures for referrals to appropriate social services following patient discharge.

This standard should be eliminated because every hospital has written policies on social services that address post discharge assistance and referrals.

Section .06A(13)-(18) have been repealed.

Section .06A(19). Minimum Size for Pediatric Unit. There shall be a minimum of ten designated pediatric beds in a unit unless:

(a) Travel time from the unit to another pediatric unit exceeds 30 minutes; or
(b) The hospital is the sole provider of pediatric services in its jurisdiction.

This standard should be eliminated because pediatric admissions have declined to such an extent that having ten beds may not make any sense.

Section .06A(20). Admission to Non-Pediatric Beds. Stable non-emergency pediatric patients may be admitted to licensed medical/surgical beds, which are separated from other adult beds, only when the quality and level of care is equal to that of a designated pediatric bed.

If previous standard is eliminated, this one should be eliminated, as well.

Section .06A(21). Required Services When Providing Critical Care. Each hospital providing critical care services shall make available, directly or through referral, health education, mental health consultation, and physical rehabilitation services for patients and, where appropriate, their families.

This standard should be eliminated, because every hospital has, at least, referral relationships for these services.

Section .6A(22). Average Length of Stay for Critical Care Units. A hospital that has, or proposes to establish, a definitive observation cost center must achieve lower case-mix adjusted average lengths of stay in its critical care unit or units than hospitals which do not have this cost center and are otherwise comparable with respect to size and type of critical care service. The hospital has a reasonable period of time (up to six months) after opening its definitive observation unit to achieve the reduced length of stay.

This standard should be eliminated, because every hospital's interest is to discharge its patients as soon as possible under the current Maryland rate setting system.

Section .06A(23) Waiver of Standards for Proposals Responding to the Needs of AIDS Patients. The Commission may waive any of the standards in the State health Plan which would prevent the approval of an application proposing to respond to the inpatient needs of AIDS patients if:

(a) An applicant can demonstrate that the waiver is in the public interest; and
(b) The Commission, in consultation with the Secretary of Health and Mental Hygiene, determines that a public health emergency exists.

This standard should be eliminated as it addresses a concern that is no longer valid.

Section .06B(1) Compliance with Systems Standards. Each Certificate of Need applicant shall submit, as part of its application, written documentation of compliance with all applicable standards in Regulation .06A of this Chapter.

This standard is redundant and need not be stated. It should be eliminated.

Section .06B(2) Duplication of Services and Adverse Impact. The Commission will only grant a Certificate of Need if a hospital seeking to establish or expand a service, or to construct a new facility, documents that none of the following will occur as a result of the project:

(a) Duplication of existing services beyond that allowed by this Chapter;

(b) If the hospital's costs are above the mean, any necessary rate increases will not change the hospital's cost ranking on adjusted Screen A, prepared by the Health Services Cost Review Commission;

(c) If the hospital's costs are below the mean, any necessary rate increase will not raise the hospital's cost ranking above the mean on adjusted Screen A, prepared by the Health Services Cost Review Commission; or

(d) Inappropriately diminishing the quality of care, access to care, or the provision of uncompensated care.

Other standards that address subsection (a), and it should be eliminated.

Section .06B(4) Burden of Proof Regarding Need. The burden of demonstrating need for services not covered by Regulation .07 of this Chapter or by other parts of the State Health Plan, including sub-services for which need is not separately projected, rests on applicants.

Since need is addressed under the CON review criterion COMAR 10.24.01.08G(3)(b) ("Need"), this standard is redundant and should be eliminated.

Section .06B(5) Discussion with Other Providers. In multiple-hospital jurisdictions with excess capacity, the Commission will only grant a Certificate of Need to a hospital not part of a merged or consolidated organization seeking to establish or expand a service, or to construct a new facility, if the applicant demonstrates in the

proposal that merged, consolidated, and shared services, programs, or facilities have been discussed with other health care providers.

The Commission has never denied a project on this basis. If it wants to force mergers, that is another matter, and this standard is ineffective in doing that. This should be eliminated.

Section .06B(9). Maximum Square Footage.

(a) For all new construction projects, the following maximum standards for departmental gross square feet per bed apply:

(i) Medical/Surgical nursing units – 325;
(ii) Intensive care and coronary care – 365
(iii) Pediatric – 300
(iv) Psychiatric – 405

(b) Square footage need for compliance with the federal Americans with Disabilities Act may be added to the maximums in (a).

(c) When the following areas are necessary, the square footage allotted must be shown to be needed when their inclusion results in exceeding the standard: solariums, patient and visitor lounges, social spaces for patients (day rooms), teaching or conference space, nurses' lounges, special purpose treatment rooms (ear, nose and throat rooms; cast rooms; group therapy and occupational therapy rooms; and others), and unit manager's office.

(d) Each Certificate of Need applicant proposing to construct unit larger than that allowed in (a) shall provide evidence that the service cannot be provided safely and effectively within the limits of (a).

This is, perhaps, the most egregious standard in the SHP. The Commission has recognized that this standard has been obsolete for ten years, but has not repealed or revised it. Since this standard is updated so rarely, the Commission should probably not have ceilings on size. It should either just cite the AIA Guidelines as minimums or establish a method for using updated sizes as standards change. Currently, architects are not designing hospitals based on the current AIA guidelines. Rather, they are using the proposed 2006 AIA Guidelines. There should be mechanism in the standard to accommodate these periods when new guidelines are pending.

Section .06B(12) Efficiency. For Certificate of Need applications that involve improved facility or service efficiency, applicants must identify the specific portion of the project for which efficiency claims are made and demonstrate that efficiencies will be realized as a result of the project.

This standard was originally intended to address applicants seeking approval for

CON projects on the basis of claimed but undocumented efficiencies. However, it should be eliminated. Realistically, it puts applicants in the difficult position of claiming efficiencies and (a) having to quantify them to the satisfaction of the Commission Staff, (b) having another item on which the Commission can find fault with the CON application, and (c) being put in jeopardy of a rate reduction. Furthermore, applicants who state that they are not claiming efficiency are being forced to respond to this standard. If the Commission wants to get address this issue, it should consider some other approach.

Section .06C(2) Compliance with System Standards. Each Certificate of Need applicant shall submit, as part of its application, written documentation of compliance with all applicable standards in Regulation .06A of this Chapter.

Again, redundant.

Section .06C (3) Conditions for Approval. The Commission will grant a Certificate of Need to a hospital proposing to renovate existing hospital beds or services, including ancillary services, only if the applicant demonstrates that the project:

(a) Will be financially feasible, after evaluating projected revenues based on historical patient utilization data from the most recent period available, as well as Commission predictions of future changes in utilization of the service in the jurisdiction;

(b) Will not have an adverse impact on the health care system, after evaluating that none of the following will occur:

(i) There will be a diminution in quality of care, access to care, or the provision of charity care as a result of the project;

(ii) Any other impact results which the Commission determines, based on substantial evidence, is detrimental to health care consumers; or

(c) Costs.

(i) If the hospital's costs are above the mean, any necessary rate increase will not change the hospital's cost ranking in adjusted Screen A, prepared by the Health Services Cost Review Commission;

(ii) If the hospital's cost are below the mean, any necessary rate increase will not raise the hospital's cost ranking above the mean of adjusted Screen A, prepared by the Health Services Cost Review Commission; and

(d) Is the optimal alternative, after considering the costs and effectiveness of the following alternatives: not carrying out the project, new construction, other renovations, merger, consolidation, closure of the service, and delivery of the service in another setting.

Subsections (a) and (b) are redundant as they are addressed by CON Review Criteria and should be eliminated.

Section .06C(5) Maximum Square Footage. A renovation project must adhere to the maximum square footage requirements contained in Regulation .06B of this Chapter.

The Commission should simply state say that the standard for new construction is applicable to all projects. Also, see prior comments.

As demonstrated above, most of the standards in this section are irrelevant and should be eliminated. The standards that I believe the Commission could keep are listed below. However, as I stated previously, all of the SHP standards should be revisited. To retain a standard, the Commission should first be required to demonstrate that there is a problem addressed by the standard and how the standard will be effective in resolving the problem or improving the system.

Section .06A (1) Identification of Bed Need

(a) Minimum and maximum need for acute inpatient medical/surgical/gynecological/addictions, obstetrical, and pediatric beds are identified using the need projection methodologies in Regulation .07 of this Chapter.

(b) Projected need for trauma, critical care, and progressive care beds, and acre for AIDS patients, is included in the calculated medical/surgical/gynecological/ addictions need projection.

(c) Additional MSGA or pediatric beds shall be constructed or put into operation such that total bed capacity increases only if:

(i) The total number of beds added does not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital pursuant to §19.307.2 of Health-General Article; or

(ii) Such addition is consistent with the jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .07 of this Chapter.

(iii) If consistent with Regulation .05c3, the total number of MSGA and pediatric beds proposed for addition may be derived through application of the projection method, assumptions and targets contained in the most recent iteration of the applicable bed need projection methodology in Regulation .07 of this Chapter, as applied to

the service area of the hospital.

Section .06B(7) Cost Per Square Foot of Hospital Space.

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift guide must demonstrate that the higher costs are reasonable.

(Note: This should be modified to refer to the Marshal and Swift Valuation Service.)

Section .06B(8) Cost Per Square Foot of Non-Hospital Space.

(a) For construction of non-hospital projects sponsored by hospitals, cost per square foot of construction must be within the limitations of the appropriate good quality Class A construction costs given in the Marshall and Swift guide for the appropriate structure.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift guide must demonstrate that the higher costs are reasonable.

(Note: This should be modified to refer to the Marshal and Swift Valuation Service.)

Section .06B(10). Approval of Project Beyond Construction Cost and Square Footage. A Certificate of Need applicant proposing construction costs of square footage above those allowed in Standards .06B(7)(a), (8)(a), or (9)(a), as adjusted by findings under Standards .06B(7)(a), (8)(b), or (9)(b)-(d), must demonstrate that all additional costs will be financed by the applicant without increases in rates.

Section .06B(11). Rate Reduction Agreement. A high cost hospital will not be approved for a Certificate of Need for the establishment of a new acute care service, or for the construction, renovation, upgrading, expansion, or modernization of acute care service, including support and ancillary services, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Section .06B(13) Expedited Review for Conversions.

(a) The Commission will grant an expedited review of a Certificate of Need application for conversions of excess acute care capacity to a non-acute health care service under the expedited review provisions of COMAR 10.24.01.07B(3), if the proposed service does not exceed a need identified in the State Health Plan and no other applicant proposes the same service to meet the same need.

(b) The Commission will approve the Certificate of this expedited review if the:

(i) Applicant demonstrates that appropriate quality of care will be assured, including meeting applicable standards established in the State Health Plan and by Federal, State, local and private accrediting bodies;

(ii) Proposed service will provide financial access to care consistent with standards for the service, or similar services, found in the State Health Plan;

(iii) Proposed service will be offered at a reasonable cost, and the hospital con document that its charges will be acceptable to payors, that is, public payors, private insurance, or private pay patients; and

(iv) Proposed service is in the public interest.

Section .06B(14) Preference for Conversion to Non-Acute Care. When a hospital proposes a conversion of excess acute care capacity of a non-acute care service subject to Certificate of Need review, the Commission may give preference to such a hospital project over a non-hospital applicant in a comparative review for that non-acute care service.

Section .06B(15) Preference for Conversion to Acute Psychiatric Care. When two or more hospitals are in a comparative review for acute psychiatric care services, the Commission will give preference to a proposal for conversion of excess acute care capacity over a proposal for new construction to provide the same services, and will give a preference to applicants who sign a written agreement with the Mental Hygiene Administration as part of an application for state hospital conversion bed need, as described in the Acute Psychiatric Services section of the State Health Plan, COMAR 10.24.07.02B.

Section .06B(16) Emergency Certificate of Need. In granting an emergency Certificate of Need requiring new construction or expansion of beds or services under COMAR 10.24.01.20, the Commission does not apply the standards in Regulation .06B of this chapter.

Section .06(C)(1). Types of Projects. The Commission will consider proposals for renovation of hospital beds or services, including ancillary services, if the applicant demonstrates that the project is needed, and addresses one or more of the following:

(a) The service needs additional space, as documented by written recommendations from appropriate accreditation and licensing agencies regarding comparisons to the departmental square footage of comparable services, or square footage standards contained in this chapter.

(b) There are operating problems which can be corrected by the proposed renovation, as documented to the satisfaction of the Commission by specific data regarding cost savings which would occur if the project is completed and for which the Commission is satisfied that the proposed level of investment is appropriate in relation to the operating efficiencies to be generated;

(c) The renovation project is being proposed to correct deficiencies that place the facility at risk of health and safety citations from licensing and accrediting organizations; or

(d) The hospital can demonstrate to the Commission's satisfaction that the renovation is necessary to maintain a modern facility in a good state of repair and acceptable to its community.

Section .06C(4) Relationship to New Construction Costs. The Commission will not approve renovation costs in excess of costs for good quality Class A new construction listed in Marshall and Swift's Valuation Quarterly.

(Note: This should be modified to refer to the Marshal and Swift Valuation Service.)

Section .06C (6) Approval of Project Beyond Construction Cost and Square Footage Standards.
A Certificate of Need applicant proposing renovation costs or square footage above those allowed in Regulation .06B of this Chapter must demonstrate that all costs will be financed by the applicant without increases in rates, and that the costs are reasonable.

Section .06C(7) Conversions to Non-Health Related Uses. Providing a hospital has delicensed excess acute care capacity, a proposal to convert delicensed capacity to a non-health care use is not subject to Commission review under Certificate of Need, including requests for exemptions from Certificate of Need review.

Section .06C(8) Excess Capacity. Where excess capacity in a jurisdiction has been

projected in accordance with Regulation .07 of this Chapter, the Commission will approve a hospital renovation project for acute care services only if one or more of the following conditions are met:

(a) The occupancy rate for the service or services to be renovated will meet the applicable minimum occupancy standards in Regulation .07D and COMAR 10.24.07.02B following completion of the project;

(b) The applicant waives its right to increase its bed complement through exemption from Certificate of Need review permitted under COMAR10.24.01until the occupancy rate for the service or services to be renovated meets the applicable minimum occupancy standards in Regulation .07D and COMAR 10.24.07.02B;

(c) If at least 50 percent of the applicant's primary service area is located within a planned high growth area designated by an appropriate governmental authority consistent with the requirements of Economic Growth, Resource Protection, and Planning Act of 1992, the applicant may retain its current complement of licensed beds without waiving its right to increase its bed complement through exemption from Certificate of Need review permitted under COMAR 10.24.01; or

(d) The project is designed and demonstrated to enhance physical and institutional efficiency.

Section .06C(9) Emergency Certificate of Need. In granting an emergency Certificate of Need requiring renovation under COMAR 10,24.01.20, the Commission does not apply the standards in Regulation .06 of this Chapter.

Conclusion

There are other potential subjects that could be addressed by new standards, if the Commission can demonstrate that they are effective means of addressing identifiable problems. For example, one issue of interest to the Commission is patient safety.

While I have used the Acute Inpatient Services section of the SHP as the example, I could have used another SHP section, as virtually every section suffers from the same problems.

Again, thank you for soliciting comments. I take the improvement of health care planning in Maryland very seriously and am heartened by the Commission's initiative. I hope that these comments are helpful to you. Feel free to call me with any questions.

Best,

Andrew L. Solberg